MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE

OSHA RESPIRATORY MEDICAL QUESTIONNAIRE

OTSG APPROVED *(Date)*

1. Your age (to nearest year):

2. Sex (circle one): Male/Female

3. Your height: ft. in.

4. Your weight: lbs.

5. Your job title:

6. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):

7. The best time to phone you at this number:

8. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

9. Check the type of respirator you will use (you can check more than one category):

a. N. R. or P disposable respirator (filter-mask, non-cartridge type only).

b. Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

10. Have you worn a respirator (circle one):

Yes/No

If "yes," what type(s):

~~Part A. Section 2. (Mandatory) Questions 1~~ through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you currently smoke tobacco. or have you smoked tobacco in the last month: Yes/No 2. Have you ever *had* any of the following conditions?

a. Seizures (fits): Yes/No

b. Diabetes (sugar disease): Yes/No

(continued top of next column)

c. Allergic reactions that interfere with your breathing: Yes/No

d. Claustrophobia (fear of closed-in places): Yes/No

e. Trouble smelling odors: Yes/No

3. Have you ever *had* any of the following pulmonary or lung problems?

a. Asbestosis: Yes/No

b. Asthma: Yes/No

c. Chronic bronchitis: Yes/No

d. Emphysema: Yes/No

e. Pneumonia: Yes/No

f. Tuberculosis: Yes/No

g. Silicosis: Yes/No

h. Pneumothorax (collapsed lung): Yes/No

i. Lung cancer: Yes/No

j. Broken ribs: Yes/No

k. Any chest injuries or surgeries: Yes/No

l. Any other lung problem that you've been told about: Yes/No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath: Yes/No

b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No

c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No

(continued top of next column)

d. Have to stop for breath when walking at your own pace on level ground: Yes/No

e. Shortness of breath when washing or dressing yourself: Yes/No

f. Shortness of breath that interferes with your job: Yes/No

g. Coughing that produces phlegm (thick sputum): Yes/No

h. Coughing that wakes you early in the morning: Yes/No

i. Coughing that occurs mostly when you are lying down: Yes/No

j. Coughing up blood in the last month: Yes/No

k. Wheezing: Yes/No

l. Wheezing that interferes with your job: Yes/No

m. Chest pain when you breathe deeply: Yes/No

n. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you ever *had* any of the following cardiovascular or heart problems?

a. Heart attack: Yes/No

b. Stroke: Yes/No

c. Angina: Yes/No

d. Heart failure: Yes/No

e. Swelling in your legs or feet (not caused by walking): Yes/No

f. Heart arrhythmia (heart beating irregularly): Yes/No

g. High blood pressure: Yes/No

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

*U.S. Government Printing Office 1994 — 300727/10398

5. Have you ever had any of the following cardiovascular or heart problems? (Cont'd)

h. Any other heart problem that you've been told about: Yes/No

6. Have you ever had any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest: Yes/No

b. Pain or tightness in your chest during physical activity: Yes/No

c. Pain or tightness in your chest that interferes with your job: Yes/No

d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No

e. Heartburn or indigestion that is not related to eating: Yes/No

f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you currently take medication for any of the following problems?

a. Breathing or lung problems: Yes/No

b. Heart trouble: Yes/No

c. Blood pressure: Yes/No

d. Seizures (fits): Yes/No

8. If you've used a respirator, have you ever *had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)

a. Eye irritation: Yes/No

b. Skin allergies or rashes: Yes/No

c. Anxiety: Yes/No

d. General weakness or fatigue: Yes/No

e. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

(continued top of next column)

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently): Yes/No

11. Do you currently have any of the following vision problems?

a. Wear contact lenses: Yes/No
b. Wear glasses: Yes/No
c. Color blind: Yes/No

e. Any other eye or vision problem: Yes/ No

12. Have you ever *had* an injury to your ears, including a broken ear drum: Yes/No

13. Do you currently have any of the following hearing problems?

a. Difficulty hearing: Yes/No
b. Wear a hearing aid: Yes/No

c. Any other hearing or ear problem: Yes/ No

14. Have you ever *had* a back injury: Yes/No

15. Do you currently have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet: Yes/No

b. Back pain: Yes/No

c. Difficulty fully moving your arms and legs: Yes/No

d. Pain or stiffness when you lean forward or backward at the waist: Yes/No

e. Difficulty fully moving your head up or down: Yes/No

f Difficulty fully moving your head side to side: Yes/No

g. Difficulty bending at your knees: Yes/No

h. Difficulty squatting to the ground: Yes/ No

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No

j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

(continued top of next column)

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your

chest, or other symptoms when you're working under these conditions: Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If "yes," name the chemicals if you know them:

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: Yes/No

b. Silica (e.g., in sandblasting): Yes/No

c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No

d. Beryllium: Yes/No

e. Aluminum: Yes/No

f. Coal (for example, mining): Yes/No
g. Iron: Yes/No

h. Tin: Yes/No

i. Dusty environments: Yes/No

j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures:

4. List any second jobs or side businesses you have:

5. List your previous occupations:

6. List your current and previous hobbies:

7. Have you been in the military services? Yes/No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

(continued top of next page)

CLINICAL RECORD

~~Report on~~ _____
or
Continuation of DA 4700 RESPIRATORY MEDICAL QUESTIONNAIRE
(Strike out one line) (Specify type of examination or data).

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No

If "yes," name the medications if you know them:

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters: Yes/No

b. Canisters (for example, gas masks): Yes/ No

c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you):

a. Escape only (no rescue): Yes/No

b. Emergency rescue only: Yes/No

c. Less than 5 hours per week: Yes/No

d. Less than 2 hours per *day:* Yes/No

e. 2 to 4 hours per *day:* Yes/No

(continued top of next column)

(Sign and date)

f. Over 4 hours per day: Yes/No 12. During the period you are using the respirator(s), is your work effort:

a. *Light (less* than 200 kcal per hour): Yes/ No

If "yes," how long does this period last during the average shift: furs. mins.

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

b. *Moderate (200* to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: furs. mins.

Examples of moderate work effort are sitting while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 Lbs.) on a level surface.

c. Heavy (above 350 kcal per hour): Yes/ No

If "yes," how long does this period last during the average shift: furs. mins.

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; *working* on a loading dock shoveling: standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 Lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No

If "yes," describe this protective clothing and/or equipment:
(continued top of next column)

14. Will you be working under hot conditions (temperature exceeding 77° F): Yes/No IS. ~~Will you be working under humid~~ conditions: Yes/No 16. Describe the work you'll be doing while you're using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance:

Estimated maximum exposure level per shift:

Duration of exposure per shift

Name of the second toxic substance:

Estimated maximum exposure level per shift:

Duration of exposure per shift:

Name of the third toxic substance:

Estimated maximum exposure level per shift:

Duration of exposure per shift:

The name of any other toxic substances that you'll be exposed to while using your respirator:

(Continue on reverse side)

Reviewed by (Name and signature of health care provider and date

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

REGISTER NO.

WARD NO.

~~REPORT ON~~ _____ or CONTINUATION OF DA 4700

Standard Form 507
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR 101-11 80 6-8
OCTOBER 1975

507-106

Part C

1. Healthcare Providers Comments to any "Yes" or abnormal responses above.
(List item number and comment.)

2. Objective Evaluation, if indicated, based on job duties.

a. Blood Pressure:

b. Visual acuity:	Near	Far	c. Spirometry:
Uncorrected			d. Other:
Corrected			

3. Assessment:

☐ Medically cleared for respirator use ☐ Optical Inserts Required

☐ Not medically cleared for respirator use. *(Explain reasoning)*

4. Disposition:

☐ Use test indicated.

Routine periodic reassessment ☐ 1 year ☐ 2 years ☐ Other frequency (state) _____

5. Reviewed by:

_____ _____ _____

(Name of health care provider) *(signature)* *(date)*